ART. XV.—*Summary of the Proceedings of the Pathological Society of Philadelphia.*

1869. *Sept. 9. Anencephalic Fœtus Born at Full Term.*—Dr. W. W. **KEEN** presented the specimen (which had been for some weeks in alcohol when it was examined) for Dr. WM. H. **FINN**. The neck, on dissection, showed everything in a perfectly normal condition, including the nerves. The vault of the cranium was entirely gone, the scalp being in direct contact with the base of the skull. No vestiges of the brain were present except some small, brownish-black, semi-solid masses of matter filling up the inequalities of the skull. Whether even this was nervous in character could not be recognized in the condition in which it was found. Some small distinct filaments, probably nervous, ran across the base of the skull to its foramina, and were connected posteriorly with the spinal cord, but they were so soft that they could not be dissected.

The spinal cord was normal. Where the medulla oblongata should be, however, it terminated in a ragged end of softened tissue. The base of the skull was rugged and uneven from irregular development, and the basilar process and surrounding parts were one large and almost perpendicular hill. The eyes were very large and prominent, but apparently perfectly developed. All other organs were normally developed, both in the thorax and abdomen.

September 23. Fibro-Nuclear and Cystic Growths, involving Ovaries and Peritoneum.—Dr. J. H. **GROVE** exhibited the specimen, and gave the following:—

Was called to see Mrs. M., aged 65, in February last. She had a tumour, giving her considerable discomfort, in the right iliac region, and encroaching upon the hypogastric region, measuring about four by five inches. In a few weeks it was noted that fluid was collecting in the abdominal cavity, and this continued to accumulate until the 4th of August, when her abdomen was much distended. Upon that day I tapped the abdomen, removing about five gallons of dark, highly albuminous liquid. At that time her lower extremities were œdematous, she was quite feeble, and considerably emaciated. The œdema almost entirely disappeared in a few days after the tapping.

After the removal of the liquid, the tumour appeared more distinct and irregular in form, while another hard mass was now detected above the first tumour. Both of these tumours could now be distinctly traced through the thin abdominal parietes.

In a few weeks, however, the liquid appeared to be again collecting quite rapidly, so that, on the 13th inst., I tapped her the second time, removing about three gallons of fluid presenting the same character as that removed by the first tapping. She died on the 16th inst., three days after the second tapping.

At the *autopsy*, I found in the abdominal cavity about three pints of liquid, similar to that removed by tapping. The pelvis was filled with an abnormal growth, completely enveloping the uterus and its appendages, the rectum and the bladder, and firmly adhering to the pelvic wall. Attached to this mass, and connected with the ovaries, were two multilocular ovarian cysts; the one on the right side being the larger.

The parietal peritoneum was quite livid and thickly covered by abnormal growths, so as to be almost entirely transformed into diseased structure.

The visceral peritoneum was thickly studded by the same sort of abnormal formation. The covering of the stomach was less involved than any other part of the peritoneum; but near to the pylorus were a few of those masses.

The omentum was completely transformed into a large, indurated, diseased mass.

The mucous membrane of the alimentary canal was normal.

All the other viscera of the abdomen were healthy, excepting their peritoneal coverings.

The lungs were perfectly healthy, but had quite extensive pleuritic adhesions on both sides.

The heart was in a normal condition, excepting slight thickening of the mitral valves.

A hurried examination with the microscope showed the growth to be made up of fibres, through which were infiltrated a large number of free nuclei, with a few fusiform cells, corresponding with descriptions given by Bennett of his fibro-nuclear tumour.

Dr. TYSON stated that he had examined microscopically *solid* parts of these growths said to have been taken from the peritoneum and ovary, and found the following elements: 1st. An imperfect, somewhat granular fibrous stroma. 2d. Scattered throughout this, and floating freely, a cellular element, composed of uninuclear cells of moderate size, free nuclei, and of form representing every grade of oval, from those a little more than round to typical spindle cells. The round and oval cells range from $\frac{1}{2000}$ to the $\frac{1}{1000}$ of an inch in diameter, and were provided with small oval nuclei, approaching the size of a red blood corpuscle, and corresponding in character with the free nuclei, which were abundant. The cells and nuclei were granular throughout, the latter more markedly so, while a number of the former exhibited complete fatty degeneration. 3d. Free oil, in drops and granules.

The fluid of the cysts was not brought to me for examination.

Dr. W. PEPPER referred to a case of colloid cancer of the omentum, which he had exhibited before the Society at a meeting in June. The present specimen appeared to him somewhat analogous, inasmuch as it presented a combination of cystic formation, with solid growths. These were also combined in the two ways most frequently met with in cystic malignant disease. Thus the omentum presented the ordinary appearances of colloid disease, save that the cysts were unusually prominent and their contents very thin; whilst the large cysts, developed in connection with the ovaries, presented an indigenous formation of small, flat, sessile, epithelioma-like growths, which closely resembled the nodules observed upon the surface of the visceral and parietal peritoneum.

Dr. H. ALLEN suggested the possibility of such conditions as those present in this case being due to peritonitis occurring years before, since in such case the peritoneum may present nodules similar to those in the present case.

Dr. W. PEPPER, in reply, remarked that this supposition appeared highly improbable to him, since the nodules of organized lymph found on the peritoneum, as the result of inflammation, are usually smaller than those here seen. In addition to this, however, the resemblance between the peritoneal nodules and the indigenous growths found in the ovarian cysts, and the condition of the omentum, seemed to preclude the idea that the morbid process had been one of simple chronic inflammation.

Oct. 14. Dr. WILLIAM PEPPER presented three specimens of *aneurism of the abdominal aorta*, two of which were seated just below the passage of that vessel through the diaphragm, the third being seated at the bifurcation of the aorta.

In each case marked erosion of the vertebral bodies had occurred, extending so deeply in one instance that the spinal canal had been opened: the intervertebral cartilages were comparatively much less destroyed.

The aneurisms were prepared as dry specimens by Jules Bailly.

Sacro-Iliac Disease, with Subsequent Occlusion of the Iliac Veins and Vena Cava. Dr. J. B. MUSTIN presented the specimens and read the following history:—

P. P., aged 25, was admitted to the Episcopal Hospital November 19, 1868, affected with what was apparently a psoas, or iliac abscess, which had opened in the left groin and was discharging freely. He was much reduced by the drain, which had existed some four months, and was confined to his bed from the time of his admission. Under the use of tonics and nourishing diet he rallied somewhat, but the discharge continued unabated. There was at first some difficulty in determining the exact seat of the disease, as neither the vertebra nor the hip-joint appeared to be diseased. A long probe, passed in at the opening in the groin, passed around the hip-joint, upon the dorsum of the ilium, and also under Poupart's ligament into the pelvis, but touched no diseased bone. The case was decided by the Attending Surgeon, Dr. John Ashhurst, Jr., to be a case of sacro-iliac disease. The pus showing a tendency to collect in the tissues of the hip, a counter opening was made over the trochanter for the freer evacuation, and another opening subsequently formed on the inside of the thigh. From these openings the pus continued to flow profusely, amounting at least to a pint daily for several months. The lower extremity on the affected side was from the time of his admission quite œdematous, showing that the circulation was seriously interfered with by the pressure of the abscess. This swelling continued to increase until the left leg was two or three times the size of the other, which was, however, quite emaciated. Livid ecchymotic spots appeared, from time to time, and the integuments threatened to slough, but did not to any great extent. The limb, however, continually exuded a watery fluid, which kept the bed constantly moist.

About the beginning of the month of March, the condition of the patient remaining otherwise much the same, the other leg commenced to swell, owing to obstructions of the circulation on that side. This œdema increased rapidly, until in a few weeks the right limb had obtained the size of the left, corresponding in its general condition with the description already given. This continued until a short time previous to death, which occurred on the 11th of July, when the leg sensibly decreased in size.

The strength of the patient held out remarkably, and the digestive functions were well performed. He had occasional attacks of diarrhœa, which yielded readily to treatment; was also troubled with chronic bronchitis, with abundant expectoration. Notwithstanding the large quantities of food and stimulus which he consumed, he gradually emaciated, and died of exhaustion about eight months after admission.

The *post-mortem* examination revealed a large cavity, with a firm wall on the dorsum of the ileum, occupying the position of the glutei muscles, and another occupying the iliac fossa. These two main cavities were filled with pus and communicated with each other through the sacro-sciatic notch, and also in front. The point of suppuration was at the junction of the left ileum with the sacrum. Both these bones were found necrosed, but especially the sacrum, which was "honey-combed" for several inches. The apex of the bone is also carious from a bed-sore, which had existed over that point.

The great œdema of the lower extremity was fully accounted for. The iliac vessels on the left side were firmly imbedded in the pseudo-membranous walls of the iliac abscess. The artery did not appear diseased, but the vein was much shrivelled and contained a firm, fibrinous clot, adherent to the walls of the vessel, and entirely obliterating its cavity. This extended upwards along the cava as far as the renal veins, and was apparently projecting into these. Below the renal veins the vena cava is entirely occluded, and ends, as it were, in a *cul-de-sac*. The clot also extends downwards into the iliac veins of the right side. The origin of this disease of the vessels appears to have been at the seat of the abscess on the left side, from pressure at that point. For the œdema existed only on that side up to May, 1869, the clot gradually increasing, and at that date reached the cava, and the right iliac vein became thus secondarily involved.

Gunshot Wound of Neck; Paralysis of Left Upper Extremity; Probable Reflex Paralysis of both Lower Extremities; Partial Recovery; Death from Phthisis three years afterwards. HARRISON ALLEN, M. D., read the following history of this case:—

Capt. ——, Penn. Cav., was wounded in a hotly contested action at Darbytown Road, Va., October 7th, 1864, by a conoidal pistol ball, which entered left side of neck, one inch above clavicle, a little to the outer side of sterno-cleido-mastoideus, and lodged. Capt. ——, at the time, was mounted, and in the act of discharging a pistol at a confederate officer, from whom he received the wound. The position of the body, therefore, was upright, and, probably, inclined slightly forward. The exact distance between the combatants is unknown, but it was not great, for the forces were engaged in a hand-to-hand fight, and a simultaneous discharge of pistols between the officers was followed by a demand, each to the other, to surrender.

Immediately afterwards, Capt. —— fell senseless from his horse, and remained in an unconscious state for four hours. Upon his recovery, it was discovered that paralysis of both lower extremities existed, while intense burning pain was experienced in palm of left hand. The precise duration of the paralysis is not known. It improved, however, some time prior to November 24th, 1864 (seventh week), the date of his transfer from general hospital, at Fortress Monroe, to the Officers' Hospital, at Philadelphia.

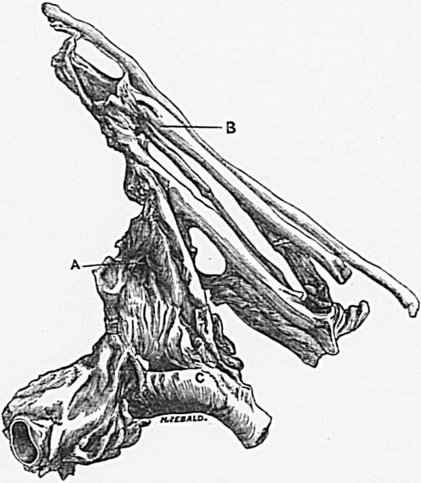
At this time the right leg enjoyed a slight degree of motion, which, by December 1st (eighth week), had increased. This was also the case with the left leg, but to a less degree. The arm remained useless and painful. As far as could be learned, the recovery of sensation preceded that of motion. By April 1st, 1865 (fifth month), Capt. —— could walk with crutches, and by May 4th had recovered sufficiently to permit him to return to his regiment. The burning pain in hand persisted, however, until August, 1865 (tenth month), when it became more endurable, but did not disappear until some time later. At the last-mentioned date he was mustered out of service.

His condition at this time was as follows: Recovery of right side of body, excepting foot, which could not be extended completely, and was sensitive to moderate degrees of cold. Recovery of motion in left lower extremity, excepting power of extension, which was impaired. In act of walking, the limb was swung outwards and forwards by a peculiar motion, probably chiefly accomplished by the abductor and rotator muscles at hip. Sensation remained obtunded.

In the left upper extremity the motion had been restored, except in the extensors and flexors of the hand. The fingers were rigid and permanently semi-flexed. The palmar pain had almost entirely disappeared, but general sensibility was diminished. The nutrition of the member was very deficient.

Capt. —— remained in this condition until November, 1866 (thirteenth month). He was able to walk distances of several squares at a time, and to attend to the duties of his occupation as clerk. In the latter part of November symptoms of phthisis set in. A severe attack of hæmop-

Fig. 1.



A. Position of particle of lead; B. Brachial plexus of nerves; C. Subclavian artery.

lysis occurred in December, and from this time the disease advanced (presenting, so far as was learned, no peculiar characters), to terminate fatally October 25th, 1867, about three years from date of reception of wound.

Autopsy.—Four days after death, body in ice. Emaciation extreme; left arm as described in last note; it was of a marble whiteness; the motions of joints perfect, excepting the fingers, which were fixedly semi-flexed.

The cicatrix on neck depressed—not puckered—about the size of a split pea, and was non-adherent.

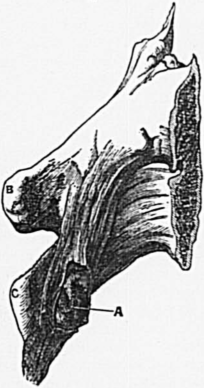
No clue was furnished as to the position of the ball. A careful dissection of the neck appeared to be the only method by which the missile could be found. The results of this examination yielded:—

1. An irregular particle of lead (Fig. 1), about the size of a mustard seed, imbedded in the connective tissue, between the brachial plexus of nerves of the left side and the corresponding subclavian artery.

2. Numerous minute, irregular particles of lead, measuring from a millimetre to half a millimetre in diameter, disseminated through the spinous process and laminæ of the first dorsal vertebra. These curiously situated granules were most conspicuous upon the inner aspect of the parts in question.

3. The ball, lodged deeply in the *right* side of the posterior cervical region (Fig. 2). It was found lying on the side of the spinous process of the second dorsal vertebra, near its tip. It was inclosed in a well-defined capsule, which was intimately associated with the spinous process above by means of a conspicuous exostosis. The ball was of lead, conoidal, and measured thirteen mill. long by nine wide. There was nothing in the form of the ball to warrant the supposition that it was of an explosive character. The spinal cord was congested. The perimembranous fluid was gelatiniform and of a decided pinkish hue. The cord was submitted to Dr. S. Weir Mitchell for examination, who pronounced it free from lesion.

Fig. 2.



A. Ball; B. First dorsal spine; C. Second dorsal spine.

Remarks.—The case is interesting, it is thought, from the following circumstances:—

1. That it is, so far as is known, the only case on record in which the course of a wound, inducing reflex paralysis, has been traced by dissection.[1]

2. That conspicuous change had taken place in and about the membranes of the cord, although there was no proof that the ball had entered the canal.

3. That the position of the ball, on right side of vertebral column, without apparent fracture of intervening bones,

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[1] See the well-known Memoir on Gunshot Wounds of Nerves, by Mitchell, Morehouse, and Keen; also, a later contribution, by S. Weir Mitchell, M. D., entitled "Paralysis from Peripheral Irritation."—*N. Y. Med. Jour.*, 1866.

as well as the presence of particles of lead in the first dorsal spine, are curious and unique.

4. That it does not follow that upon the extraction of a simple conoidal ball we have removed from the body all the lead which entered it.

Oct. 10. *Cystic Disease of Kidney, with Ulcer of the Stomach.*—Dr. MUSTIN presented the specimens for Dr. C. B. NANCREDE, who furnished the history:—

J. S., æt. 59, admitted July 30, 1869. On admission complained of pain in the region of left kidney, increased by motion or pressure, which he had been suffering from for about ten days, with great emaciation. Before admission urine had been scanty, high coloured, and apparently, from his account, bloody. When examined after admission it appeared normal though still scanty, neither albumen nor casts being discoverable. Under use of diuretics it resumed its normal amount and appearance. There was great hyperæsthesia of abdominal parietes. During greater portion of day but little fever, increasing however towards evening, for the first month, afterwards not perceptible.

During the first week of August diarrhœa and vomiting commenced, and continued with varying intensity until death took place. No permanent effects could be produced by medicines on these discharges, especially towards the last, when they were perfectly uncontrollable. He also had a short, spasmodic cough with but little expectoration. The abdominal pain during the first few weeks was intense, but abated in part under the use of large doses of opium.

When admitted, he had in addition to the above-mentioned symptoms, a singular universal tremulousness, and later in the disease had several well-marked hysterical convulsions. On the access of the vomiting, or shortly after, an almost gangrenous odour of the breath was perceived, at first entirely removable by the use of creasote, latterly only in part. On careful examination on many occasions no disease of the lungs or throat could be discovered to account for it. Three days before death the pain in the lower portion of the thorax increased, and he died in a typhoid state seventy-three days after admission.

Sectio cadaveris sixteen hours after death.—On opening the abdominal cavity no signs of disease were immediately apparent; but on examining the region of left kidney, it was apparently absent. On examining further, however, a fluctuating tumour was found which proved to be the kidney distended by fluid. It was firmly bound down to the surrounding parts. The other kidney was easily removed, was firm and much congested. Stomach was also removed, and presented several congested spots apparently eroded. The heart was natural; right lung bound down by moderately recent adhesions; bladder rather small.

On examining the left kidney microscopically, both pyramidal and cortical portions were found much atrophied and fatty, with the pelvis largely distended and stricture of the ureter.

Dr. TYSON desired to know whether a microscopic examination had been made of the condition of the capillaries of the stomach. In a stomach which was the seat of hemorrhagic erosion and ulceration, exhibited by him in June of this year, and which accompanied fatty and contracting kidneys, the bloodvessels of the stomach were the seat of granular degeneration. In the case now reported the renal disease was plainly the reresult of obstruction, and is accompanied as well by hemorrhagic erosion and ulceration of the stomach. If now a granular change of the blood-vessels of the stomach be found to exist, it will be evidence, if any relation exist between the condition of the kidneys and that of the stomach, that the former is causative, and that the condition of the latter and the symptoms arising therefrom are the result of an effort at substitutive elimination; whereas, in Dr. Tyson's case, although such an inference is possible, yet it is equally possible to infer a general cause operating to produce both effects. A single instance, however, like this one of obstructive disease, will go further than a large number where there is no way to determine the exact seat of the primary lesions; a minute examination of the stomach becomes therefore of great importance.

On motion a committee was appointed to make such examination. The chair appointed Dr. Tyson and Dr. Mustin, who submitted the following—

Report.—The committee appointed to make a microscopic examination of the vessels of the stomach which accompanied the specimen of cystic kidney presented October 14, and which appears the seat of ulceration and hemorrhagic erosion, report that they find these capillaries the seat of a granular and fatty degeneration beyond a degree which could have resulted from maceration. The gastric tubules, also, exhibited advanced fatty change, being in places packed with oil globules of considerable size, while their proper lining cells had disappeared.

Oct. 28. *Rupture of Liver. Death on tenth day from Internal Hemorrhage*—Dr. HUNTER exhibited specimens and read the following history:—

James Murphy, æt. 26, seaman, admitted to Pennsylvania Hospital October 3, 1869, for injuries received by jumping from a third story window while in a partially intoxicated condition. On admission presented marked symptoms of shock; there were no external wounds, nor could I detect any fracture. Patient complained of great tenderness and intense pain in right hypochondriac region when first admitted, nor was he entirely free from them till he died. Had repeated attacks of vomiting nearly every day, which were not controlled by the usual remedies. The vomit consisted principally of ingesta and bilious matter, but on the third and fourth days clots of blood were discovered in the matters vomited. The stools, likewise, on these days, contained small masses of blood. The countenance at all times was anxious, and he complained of severe pain in region of liver. The treatment consisted of perfect rest, morphia in large doses, and counter-irritants to right hypochondriac region. Died on the 13th.

Autopsy, nine hours after death, confined to chest and abdomen. The body was much emaciated, and its surface decidedly jaundiced. Found no lesions in thorax. On opening the abdomen I found the peritoneal sac filled with a bloody fluid. There were several large clots of blood clinging to the liver, in truth almost completely enveloping that organ. When these clots had been removed, an extensive rupture of the right border involving the entire thickness of the liver, and to a depth from the thick edge of one and a half inches on upper, and nearly two and a half inches on under surface, was discovered. The liver in the vicinity of the laceration was connected to the diaphragm by bands of recently organized lymph. Decided efforts towards a spontaneous cure appear to have been made, as quite a portion of the lacerated hepatic tissue had become united by the fibrin of the extravasated blood The gall bladder and its duct had escaped injury. I was unable by a superficial examination, to find any lesions of the coats of the stomach or intestines, save two or three ecchymosed patches. The other abdominal viscera appeared normal. There were no evidences whatever of general peritonitis, as the peritoneum everywhere, except around the liver, presented its characteristic polished surface.

Dr. **William Pepper** exhibited *a femur which on section presented necrosis* of the middle two-thirds of the original compact shaft. The cancellated tissue of the shaft had retained its vitality and its connection with the cancellated tissue of the articular extremities, and then had an enormous production of compact bone upon the exterior of the original shaft, which thus formed a cylinder of white necrosed bone, entirely unattached but imbedded between the cancellated tissue within and the new-formed compact tissue externally. The exterior of the bone was roughened and nodulated, and presented two small fistulous tracks communicating with the tubular sequestrum above described. No history could be obtained of the case from which the specimen was derived.

Fatal Hemorrhage from the Liver in an Infant.—Dr. **Hodge** was recently called upon to make a post-mortem examination of a baby two and a half days old, considered by its attending physicians and parents to have been perfectly healthy until its sudden death. The abdominal cavity was found filled with blood partly fluid and partly coagulated. Its source was finally traced to the liver, of which the peritoneum covering part of the inferior and part of superior surface of right lobe had been dissected up by the effused blood. No other lesion was found.

Dr. William Pepper suggested that the hemorrhage in this case might have occurred from the rupture of the peritoneum covering a large growth of cavernous tissue. This peculiar formation which, as described by Rokitansky, is especially common in the peripheral portions of the liver, presents on section a tissue like that of the corpora cavernosa, consisting of cells filled with fluid dark blood. There is usually a connection with some large portal vessel, and from the superficial position of the growth, a rupture might readily occur and be followed by profuse hemorrhage.

Nov. 11. Dr. **Harlan** showed a small piece of cancellated bone, about an eighth of an inch in diameter, which had been expectorated from the lungs of a little girl, at the Children's Hospital, twelve years of age. "The patient is the subject of spine disease, from which she has been suffering for four years. There is very great deformity—posterior curvature—involving the dorsal vertebræ from the 6th to the 10th, inclusive. There is no history of the case beyond the very imperfect one that can be derived from the child's own account of herself. She states that for the last two years she has had more or less cough and expectoration. She has now occasional, but not violent, cough, and abundant expectoration of nearly pure pus. Careful physical examination reveals no decided sign of tubercular deposit, or other disease of the lungs sufficient to account for the amount of expectoration. On suggesting to the assistant physician the possibility that the pus might come from an abscess connected with the vertebræ, I was informed that a piece of bone had been found in the sputa. The other day this piece—much smaller than the first—was expectorated. The child states that it gave a good deal of pain in its passage, and left 'a scratching feeling in the wind-pipe, as if there was something sharp in there still.' It has not been examined microscopically, but I think there is scarcely any doubt of its nature."

Dr. W. W. **Keen** recalled a case published in the work on *Gunshot Wounds and Other Injuries of Nerves*, by Drs. Mitchell, Morehouse, and himself, in which a sharpshooter received a ball which, removing two teeth and ploughing up the tongue, lodged in the third cervical vertebra. Later, some seventeen pieces of bone were discharged from the body of the vertebra, and one-half of the wall of the vertebral foramen; yet the man recovered so completely that he re-enlisted in the Volunteer Reserve Corps.

Dr. **Ashhurst** referred to cases reported by Wade, Keate, and Mercogliano, in which large portions of vertebræ had come away through the mouth. In the cases recorded by the first two writers, considerable portions of the atlas had exfoliated. He suggested that the specimen should be examined microscopically, in order to ascertain if it were really, as it appeared to be, composed of bone. In accordance with this suggestion, the specimen was referred to a committee, consisting of Drs. Hargadine, Keen, and Mustin.

Report.—The committee appointed to examine microscopically the specimen of supposed bone, expectorated by Dr. Harlan's patient, report that they unhesitatingly pronounce it to be bone tissue, the canaliculi, lacunæ, and Haversian canals being discernible. The specimen has the appearance of having undergone long maceration, the organic constituents being in great part removed.

Examination of Persons who had been Hung.—Dr. **Keen** had an opportunity of examining the bodies of two criminals who had been hanged and had fallen about five feet. In one, the hyoid bone was fractured, but in neither case was there fracture of the vertebræ. As the spinous process of the atlas is wanting, while that of the axis is well developed, there is between the occipital and the spinous process of the axis a marked depression, filled out by the soft parts.

Unless the existence of this depression is borne in mind, we may be easily led to an incorrect diagnosis of displacement of the atlas either by fracture or dislocation.

Hydrencephalocele.—Dr. **William Pepper** presented a specimen of this, preserved as a dry preparation of the entire skeleton. The birth occurred in the lying-in ward of the Philadelphia Hospital, under the care of Dr. Duer. The child was stillborn, after a tedious labour caused by the difficulty of inducing the head to engage at the superior strait.

The child presented a sac hanging from the occipital region, fully four inches in diameter. On opening this, the dura mater and arachnoid were found to invest its inner surface. The cavity of the sac communicated with the cranial cavity by an abnormal opening in the occipital bone three-quarters of an inch in diameter, seated a short distance above the foramen magnum. The brain was partly contained within the cranium, but in part lay outside of the cranial cavity in the abnormal sac above described. There was no other anomaly whatever about the skeleton.

Degenerated and Atrophied Hydatid Cyst in the Liver.—Dr. **Mustin** exhibited the specimen for Dr. **Nancrede**, and made the following remarks:—

The specimen presented was taken from the body of a man who died in the medical ward of the Episcopal Hospital; a yellow cicatricial spot was noticed on the upper surface of the right lobe of the liver about as large as a silver dollar. On cutting through this, a cyst somewhat larger than a walnut was found, with a fibrous wall in some places cretaceous, containing a yellow gelatinous substance of the consistence of calves' foot jelly; this was divided into segments resembling sections of an orange, and the interstices filled with a cretaceous substance. On chemical examination this proved to be composed of alkaline carbonates, with a fatty matter soluble in ether; under the microscope it presented granular amorphous matter, plates of cholesterin, and oil globules. In the gelatinous substance were found numbers of the characteristic hooklets of the echinococcus; some of which were also noticed in the cretaceous portion. The only other appearances seen in the fluid were granular matter, fat, oil globules, and crystals of cholesterin. No complete echinococci were found, and no free fluid. The cyst had evidently become much atrophied. The liver was not distorted in shape. No similar formations were found in other portions of the body. The man had taken corrosive sublimate with suicidal intent, and was admitted to the hospital under an assumed name, so that nothing is known of his previous history, or of the symptoms which this disease may have at any time produced.

Blood Tumour.—Dr. D. H. AGNEW exhibited the specimen, and gave the following account of the case:—

Stephen G. G——, male, æt. 23, by occupation a farmer, presented himself at the clinic of the University of Pennsylvania, October 23, 1869, with a tumour occupying Scarpa's triangle. It was elastic to the touch, with a very indistinct sense of fluctuation, measuring about four and a half inches by three inches, and ovoidal in form. When firmly pressed upon, some movement could be detected, but only when thus pressed. No sound however, could be heard. Its size was not influenced in any way, either by pressure on the femoral artery above or below. The tumour could be moved or partially displaced from its bed. He represented himself as being exceedingly fond of jumping, leaping at one time the distance of twenty-seven feet—this I think would admit of some subtraction. It was after a feat of this kind, twenty-two months before his admission, that he discovered a swelling the size of a hickory-nut in the groin, unattended with pain or any unusual discomfort. Its growth from that period until his admission into the hospital ward of the College has been steady, and produced then some uneasiness, a tired or weary feeling in the limb. The introduction of the exploring needle disclosed the presence of blood, which materially reduced the size of the tumour as it flowed along the groove of the instrument. On the withdrawal of the needle the tumour soon became tense and full. Its nature was decided to be a cyst containing blood, either formed from the femoral or saphena veins.

I removed it at the clinic of the College. In detaching it from its surrounding connections, it was found to have produced the absorption of a portion of the fascia lata, uncovering thereby the sartorius, and lying directly over the femoral vessels; but on its inner and under aspect, a vein was found, doubtless the saphena, leading into the growth, which was tied before detaching. When the sac was laid open, the continuation of this vessel was found in its interior with several tributary branches, also a quantity of coagulated blood, with much that was fluid. The wall would seem to be formed of the surrounding cellular tissue, adherent to the vein just without the opening in its walls.

Dr. ASHHURST commented upon the symptom mentioned by Dr. Agnew, that this tumour had always exhibited fluctuation, which would render it probable that the contained blood had remained in a fluid condition from the time of its effusion. He referred to the views of Mr. Baker [*St. Bartholomew's Hospital Reports*, vol. i. pp. 201–223], that the fluid blood contained in tumours was usually the result of disintegration of a previously formed coagulum, rather than normal blood in an uncoagulated state, and also referred to a specimen of mammary tumour, which he had himself exhibited to the Society [*Am. Journal of Medical Sciences*, April, 1864, p. 430], in which were two cysts containing fluid blood, the origin of the disease in that case, as in Dr. Agnew's, having been traced to a traumatic cause.

Dr. W. PEPPER said the remarks of Dr. Ashhurst suggested two cases, illustrative of the condition referred to, and one of which was interesting from its rarity. The first was a cyst removed by Dr. Agnew at the Pennsylvania Hospital, from over the spine of the scapula of a little boy. It had a very dense wall, and on being opened was found to contain fluid blood. Microscopically it appeared to contain no white corpuscles, but a full proportion of red corpuscles fully formed. The interior of the cyst presented a serous aspect.

The second case was that of a boy who fell, and was struck by a cart in the right side of the abdomen; the injury was very quickly followed by marked enlargement of the abdomen, which fluctuated distinctly on palpation. It was at first supposed to be a case of ascites, but the swelling was not perfectly symmetrical. After numerous efforts at evacuant treatment, a puncture was made, and a number of quarts of transparent light yellow fluid of low specific gravity were withdrawn, containing a little chloride of sodium, and leaving a little residuum after evaporation. Towards the close, the discharge began to grow turbid and bloody. There was marked diminution in the size of the abdomen, but on palpation there was found a solid mass remaining. The fluid again accumulated and was again drawn off, leaving an indurated mass of crescentic shape, extending from the right of the epigastrium down far into the abdomen. The most plausible explanation appeared to be, that there had been a large effusion of blood which had become circumscribed, and that a complete separation of the serum from the fibrin and corpuscles had taken place. The former was drawn off, leaving the latter remaining as a coagulum. The fluid again formed by breaking down of the clot, and was again drawn off. The large mass remained in the abdomen, but the boy appeared in good health. We have here, probably, a case of the kind mentioned by Mr. Baker, as most common.